PUBLIC HEALTH, WELFARE & SAFETY
Exhibit No. 4
Date F8137, 2007
Bill No. SB 312

2/8/07

To: Montana Legislators
Re: Economic/Conflict of Interest Credentialing

Traditionally physicians managed outpatient medical services and hospitals managed inpatient medical services. In the 1990's the American Hospital Association outlined a plan for hospitals and corporations to move into the outpatient arena. Today, your local physicians and other small business entrepreneurs are in competition with hospitals and large multi-billion dollar out-of-state health corporations to provide outpatient medical services.

Unwilling to responsibly partner with physicians and unable to improve quality of care, inefficiencies in service, high cost, and low patient satisfaction hospitals and health corporations have responded locally, state wide and federally with a standard playbook which includes:

1. Claiming physicians are "greedy" and "cherry picking" profitable services.
2. Implementing sham peer review and labeling physicians "disruptive" in order to remove them from the hospital staff.
3. Claiming poverty and threatening communities with hospital closure unless given unregulated monopoly status.
4. Attempting to preclude physician ownership in hospitals/outpatient centers.
5. Attempting to legalize Economic/Conflicts Credentialing.

Health corporations want to legalize economic/conflicts credentialing so they can force physician referrals to their own for-profit centers and eliminate physician competition.

One fundamental flaw underlying economic/conflict of interest credentialing is the supposition that the physician-hospital relationship is one in which there can exist a "conflict of interest". Such a relationship can exist only with the consent of both the hospital and the physician and when both agree that the physician is an "agent" of the hospital. As an agent he/she would then have a "fiduciary" duty to the hospital. In this context it would mean that: "The physician is an agent of the hospital obligated to act solely for the *benefit of the hospital* in all matters related to the physicians' hospital practice."

As to agency, hospitals vigorously oppose any suggestion that the members of the medical staff are agents of the hospital with respect to treatment decisions as they could assume liability for those decisions. Additionally, courts have found that physicians do not undertake agency obligations to the hospital with respect to how they treat their patients; how they run their medical practices; whether they invest in patient care entities; or where they refer their patients.

As to acting for the benefit of hospitals, physicians cannot ethically pledge to act for the benefit of hospitals because they have already pledged that duty to their patients. Any doctrine or rule that required physicians to consider the hospital's financial interest in making treatment decisions would interfere with the physicians' obligations to patients.

Hospitals and physicians agree that their relationship is not one in which there can be an "agency" or a "fiduciary" duty. Consequently no "conflict of interest" can exist.

That the physician is obligated to act solely for the benefit of the patient in matters related to the patient-physician relationship is a "fiduciary" duty of the highest order. It is the foundation of medical ethics and the physicians' oath. This duty involves every element of trust, confidence, and good faith and is especially important in protecting patients during treatment. Physicians meet this duty even when it is not in their own financial interest.

Allowing economic/conflicts credentialing is to allow large multi-billion dollar out-of-state health corporations and hospitals to impose their own financial interests upon the patient-physician relationship and strip mine communities of their resources.

In front of this committee is a bill to ban economic/conflicts credentialing. I ask the members recommend that Montana join the many other states that have outlawed this unethical interference in the patient-physician relationship.

Sincerely,
David Chamberlain M.D.

January 22, 2007

To: All Montanans

From: Your Independent Physician

RE: Economic/Conflicts Credentialing

Dear Patients,

As stakeholders in the healthcare of all Montanans, your independent physicians and providers are concerned with the local, state, and national efforts to impose economic and conflicts credentialing on hospital medical staffs. We believe that the best health care can only be provided when the medical staff and medical decision making process is independent from interference by hospital administrators and the business interests of multi-billion dollar out-of-state health corporations.

The environment of modern health care is one of increasing cost, decreasing reimbursement and costly regulatory scrutiny. Independent physicians more than hospitals are being effected by these factors and have driven innovation in health care by creating ambulatory surgery centers, specialty hospitals, imaging centers, and other ventures that offer improved patient care at a lower cost and physician participation in technical fee income. With the success of these ventures many not-for-profit hospitals have gone outside the hospital walls to invest in for-profit ventures of their own. Some hospitals and systems have chosen to partner with physicians and other providers in mutually beneficial ventures, while others have chosen to impose penalties on physicians, such as loss of hospital privileges. These hospitals seek to preclude physicians with ownership interests outside the hospital from practicing in the hospital.

Economic Credentialing is a physician term referring to the use of economic criteria unrelated to individual character, qualifications, professional competence, training, experience, or judgment to make credentialing decisions. Conflict of Interest Credentialing, or more commonly, Conflicts Credentialing, is a hospital term referring to credentialing based upon the presence or absence of financial relationships with entities that hospitals deem to be competitors (FN1). Those physicians with financial relationships are denied (FN2), or lose (FN3) credentials.

Both the American Medical Association (AMA) and the American College of Medical Quality (ACMQ) have issued position statements denouncing the use of economic criteria in credentialing decisions. Both organizations have expressed concerns that economic credentialing practices would impede the professional's role as the patient's advocate (FN4). In its statement the ACMQ wrote that: "Credentialing must be the exclusive product of qualified and objective review, utilizing criteria directly related to the quality of patient care...(FN5)." Conversely, the American Hospital Association (AHA) has taken the stance that hospitals must be permitted to establish policies believed necessary to protect the hospital's economic interests (FN6). Hospitals want to hold physicians financially responsible for the economic well being of the hospital.

While it is true that physicians and hospitals may have conflicting interests, the term "conflict of interest" applies only to situations where a person has a "fiduciary" duty that is incompatible with his or her personal interests (FN7). These "fiduciary" duties arise when a person, the agent, is obligated to act solely for the benefit of another, the principal, in all matters related to the agency (FN8). The physician-patient relationship is a fiduciary duty of the highest order involving every element of trust, confidence, and good faith (FN9). It is the basis of the physicians' oath, many legal obligations to patients and the basis of medical ethics. Hospitals do not pledge a similar oath to patients.

The fundamental flaw underlying conflicts credentialing is the presupposition that a physician's medical staff membership creates the type of relationship that can give rise to a "conflict of interest" (FN10). Such a relationship can only exist with the consent of both the hospital and the physician and when both agree that the physician is an "agent" of the hospital (FN11). Fearing liability, hospitals vigorously oppose any suggestion that private members of the medical staff are agents of the hospital with respect to treatment decisions (FN12). Courts have found that physicians do not undertake agency obligations to the hospital with respect to how the treat their patients; how they run their medical practices; whether they invest in patient care entities; or where they refer their patients (FN13). As both hospitals and physicians agree that a physician's membership on a hospital staff does not make him/her an "agent" of the hospital, consequently, the physician cannot have a "conflict of interest" with the hospital regarding treatment decisions

The primary fiduciary responsibility of the physician is to put the best interest of the patient first. Any doctrine or rule that required physicians to consider the hospital's financial interest in making treatment decisions would interfere with the physician's obligations to patients (FN14). Ethically, a physician cannot pledge to act in an "agency" or "fiduciary" manner with a hospital without compromising his/her primary responsibility to patients. Like our own system of government where there is separation of powers, physicians and hospitals have separate responsibilities that must be maintained in order to protect patients. Whether at the local, state, or federal level, no law or regulation should interfere with the physician-patient relationship.

At local, state, and federal levels hospital administrators maintain that physician investment in outpatient services is driven by "greedy doctors", "cherry picking" profitable services that hospitals need (FN15). The reality is that many physicians who have become investors in outpatient centers, have done so in response to inefficiencies, increased costs and decreased patient and physician satisfaction associated with outpatient services offered by hospitals (FN16). Physicians note that these same hospitals are part of multi-billion dollar out-of-state corporations. Local citizens note these corporations are using religious affiliations and not-for-profit status to "strip mine" tens of millions of dollars from their communities tax-free. The same not-for-profit hospitals that cry poverty hypocritically start their own for-profit outpatient ventures and claim they need "conflicts credentialing" so the hospital can compete. They then threaten communities with hospital closure if physician investors are "allowed" to compete with them in the free market for outpatient services.

By improving patient and physician satisfaction with the services offered by the hospital and by demonstrating a willingness to partner with physicians in ethically and financially responsible ventures, local hospitals could have aligned patient, physician, and hospital interests. Instead many have chosen the path of subordinating patient care and physicians' interests to those of their corporate bottom line. Locally owned hospitals, governed and administered by community members, could pledge a "fiduciary" responsibility to the communities in which they serve, instead of a "financial" responsibility to the multi-billion dollar out-of-state corporations they now serve.

The obvious acrimony surrounding conflicts credentialing disputes suggests that hospitals resort to conflicts credentialing when they are unable or unwilling to maintain positive relationships with their medical staffs through more cooperative means (FN17). In Butte, hospital administrators have attempted to implement economic credentialing against medical staff wishes, unilaterally amended the staff bylaws, bypassed the physician peer review process, removed physicians from medical staff without cause, and tried to unseat the physician elected medical staff president. Similar incidents have led to lengthy and expensive lawsuits (FN18) with no benefit to patients and local communities. Local hospital boards need to critically evaluate administration claims that conflicts credentialing is the only way to align physician and hospital interests. Patients will suffer if they do not meet this obligation.

During this legislative session, lawmakers have before them bills sponsored by hospital associations to allow economic/conflicts credentialing in Montana. Additionally, there is a bill sponsored by the Montana Medical Association to join the other states that have banned economic credentialing. Your independent physicians encourage you to contact your legislators and voice your opinion. The quality of health care you receive in Montana depends on your participation and support of your local physician.

Foot Notes

(FN1) Mark Taylor, *Striking Back at Doc Investors*, 34 Modern Healthcare (January 26, 2004).

(FN2) Mahan v. Avera St. Luke's Hosp, 621 N.W. 2d 150 (S.D. 2001).

(FN3) Mark Taylor, *Striking Back at Doc Investors*, 34 Modern Healthcare (January 26, 2004).

(FN4) According to the AMA, conflicts credentialing policies "are really instituted to eliminate referrals to competing hospitals and other outpatient facilities that are more convenient, cost effective or clinically appropriate for patients." AMA Response to OIG Solicitation of New Safe Harbors and Special Fraud Alerts, Letter from Maves to Janet Rehnquist (February 6, 2003).

(FN5) AMA, Policy H-230.976: Economic Credentialing.

(FN6) American Hospital Association (AHA), Letter to OIG regarding credentialing practices under Anti-Kickback statute.

(FN7) Black's Law Dictionary defines "conflict of interest" as a real or seeming incompatibility between one's private interests and one's public or fiduciary interests. Black's Law Dictionary (Bryan A. Garner ed., 7th ed. 2000).

(FN8) United States v. Mett, 65 F. 3d 1531, 1538 (9th Cir. 1995).

(FN9) See, e.g., Lockett v. Goodill, 430 P.2D 589, 591 (Wash. 1967).

(FN10) Robert J. Milligan and Michelle R. Notrica, *Plato o Plomo: Hospital Medical Staff Relations in the Era of Conflicts Credentialing*, American Health Lawyers Weekly (September 1, 2004).

(FN11) United States v. Mett, 65 F. 3d 1531, 1538 (9th Cir. 1995). Restatement (Second) of Agency subsection 1.

(FN12) Children's Med. Ctr. of Dallas, 27 S.W.3d 675, 683-84 (Tex. App. 2000). Haven v. Rand F. Supp. 538, 542 (D.D.C. 1972). Espalin, 27 S.W.3d at 683-84; Haven, 342 F. Supp. at 54.

(FN13) This view has been endorsed repeatedly by the Centers for Medicare and Medicaid Services; see e.g., 64 Fed. Reg. 63, 536-37 (November 19, 1999).

(FN14) The Ethics in Patient Referral Act of 1989, 42 U.S.C. subsection 1395nn; The Anti-Kickback Act, 42 U.S.C. subsection 1320aa.

(FN15) Physicians have no intention of yielding the high ground on this issue. One commentator has opined that when hospitals make credentialing decisions by factors unrelated to quality of care they trigger "severe ethical and legal concerns that jeopardize the physician-patient relationship. Judith E. Orie, *Economic Credentialing: Bottom-Line Medical Care*, 36 Duq. L. Rev. 437,448 (1998).

(FN16) Federal Trade Commission and Department of Justice Report, *Improving Health Care, A Dose of Competition* 13-14 (July 2004).

(FN17) Milligan and Notrica, supra note 10.

(FN18) See e.g., Medical Staff of Community Memorial Hospital of San Buenaventura v. Community Memorial Hospital of San Buenaventura Superior Ct. of Ventura County, April 24, 2003.